MARKET INSIGHTS

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Telemedicine:
What Happens Now that the Public Health Emergency has Ended?

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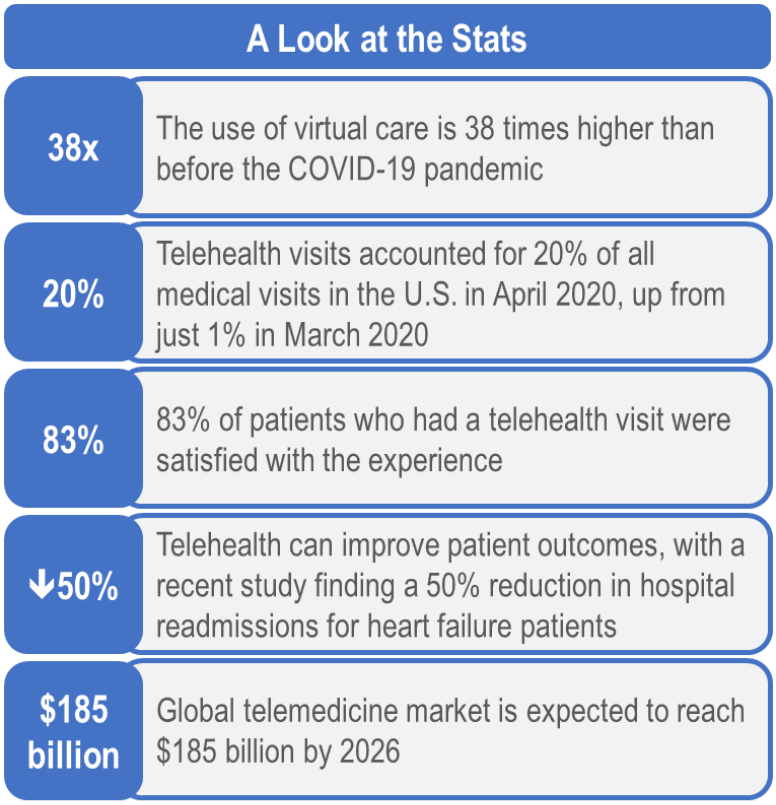
As one leader of a large inpatient telemedicine company recently said, "Telemedicine is not a "What" anymore but a "When." The stats show it. The COVID-19 pandemic solidified this trend.

On January 31, 2020 Secretary Alex M. Azar, II initiated the first Public Health Emergency ("PHE") Response regarding the coronavirus. This was a critical step in providing necessary untying of certain restrictions to allocate resources to fight the virus. Perry Halkitis, PhD, MS, MPH, dean and professor of biostatistics and urban-global health in the School of Public Health at Rutgers University said, "When we declare a disease a public health emergency, certain restrictions are loosened. Funds are made more available to help bring an end to that pandemic or to that outbreak or to that disease. So, with regard to COVID-19, there are implications for testing, for vaccines, and for treatment that will be affected by the end of the public health emergency."[1] Included among those was the relaxation of telemedicine restrictions in many areas.



Sources: McKinsey, AMA, University of Rochester, Fortune Business Insights

What happens to telemedicine now that the PHE ended May 11? While I think we can all agree that telemedicine is here to stay, I believe the pressure to end many of the restrictions that are extended only through the end of 2024 will continue to build. Setting up the ongoing regulatory oversight specifically for telemedicine will be key to ensure application at the state level and with commercial insurance payors can be more consistent.

Certain elements of the PHE impact on telemedicine are considered permanent (many of them around the issue of behavioral health) but others will expire on December 31, 2024 as a result of the Consolidated Appropriations Act of 2023 passed by Congress. Regarding the expiration date, while commercial payors such as Aetna and Blue Cross may differ, as well as State Medicaid, trends tend to follow Medicare.

The following is a summary of both permanent changes and those that will expire at the end of 2024.

[1] https://www.ajmc.com/view/end-of-the-national-public-health-emergency-for-covid-19-what-does-it-mean-for-the-public-

PERMANENT CHANGES

Behavioral Health Related

1. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can service as a distant site provider (i.e., where the healthcare provider providing the telemedicine service is physically located). The fact that patients now can be seen at these types of locations for behavioral/mental telehealth services is key for underserved areas of the U.S. population. With FQHCs in both urban and rural areas and RHCs focused on where health professionals are in short supply and rural areas that are generally medically underserved, a greater percentage of Americans now have access to critical mental health care services.
2. Medicare patients will be able to receive telehealth services in their home.
3. Audio communication only will be allowed to deliver behavioral health services.
4. Removal of geographic restrictions for originating site, i.e., the physical location of the patient.

Emergency Care

Rural Emergency Hospitals (REHs) located in certain rural designated areas will be accepted as originating sites. The REH designation is designed to maintain access to critical outpatient hospital services in communities that may not be able to support or sustain a Critical Access Hospital or small rural hospital.

TEMPORARY CHANGES – End December 31, 2024

As mentioned above there will continue to be pressure at the federal level to make more of these permanent.

1. Telehealth can be used to provide the acute hospital care at home services and be reimbursed by Medicare.
2. Physical Therapists, Occupational Therapists, speech language pathologists and audiologists will be added to those providers able to provide telehealth services.
3. Telehealth done by audio will continue to be reimbursable.
4. Distant site and originating site flexibility will continue to be maintained for telehealth visits.
5. FQHCs and RHCs can be considered either distant site providers or originating site providers for telehealth.

In addition to the above, there are other areas of concern that are likely to have a profound impact now that May 11 has passed. There is strong push by the telemedicine industry to force flexibility in guidance by the Health and Human Resources Office of the Inspector General.

AREAS OF CONCERN

1. Payment parity with Medicare, such as at a patient's home, is expected to end this year. Lower reimbursement rates could be the outcome creating pressure for some services.
2. Certain elements related to remote patient monitoring and telehealth related to reduction or waiver of cost-sharing obligations with patients will go away this year unless guidance or formal extensions are provided.
3. The ability to prescribe controlled substances through telemedicine has ended. This will impact patients who were never seen in person but only through a telehealth visit. The DEA is under considerable pressure to permanently change these elements all contained in the Ryan Haight Act.
4. Procedures now require in person supervision and not allowed to be supervised virtually.

As mentioned above, there are strong lobbying efforts by many parties in the telemedicine ecosystem to ensure that not only some of these areas are addressed by further extending them but by making these changes permanent.

Telemedicine is here to stay. It truly is the great equalizer in healthcare. Let's make it that way by addressing ALL of the relevant items that either expire at the end of 2024, end of this year, or have already expired in May. It is critical for our healthcare system going forward.

About the Author

Robert E. Annas serves as a Senior Managing Director with SOLIC Capital. Mr. Annas has over 25 years of experience in both operating and restructuring roles, including 15 years of working and advising in turnaround situations, distressed and special situation portfolio management, and distressed control private equity investing. In addition, he specializes in providing critical positioning, investment analysis, diligence, and execution support, facilitating acquisitions and divestitures through a multitude of different transaction vehicles.

Prior to joining SOLIC, Mr. Annas was a Managing Director at Navigant Capital Advisors, LLC, serving as leader on a wide variety of restructuring and operating restructuring engagements. Prior to Navigant, he was a Partner at Atlanta Equity Investors, LLC, a middle market-focused private equity fund. Mr. Annas has vast industry experience including healthcare, business services, information technology, manufacturing, distribution, transportation, consumer products, and retail.

Mr. Annas is a founding board member of Eagle Telemedicine, LLC one of the largest inpatient telemedicine companies in the U.S., providing mainly inpatient telemedicine services to over 350 hospitals through over 14 different specialties.

Mr. Annas received his Master in Accountancy, as well as Bachelor of Science in Business Administration, from the University of North Carolina. He holds an AIRA certification as a Certified Insolvency & Restructuring Advisor and is FINRA Series 79 and Series 63 licensed.

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